

§ 455.14 Preliminary investigation.

If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

[48 FR 3756, Jan. 27, 1983]

§ 455.15 Full investigation.

If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action, as appropriate:

(a) If a provider is suspected of fraud or abuse, the agency must—

(1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under § 1002.309 of this title; or

(2) In States with no certified Medicaid fraud control unit, or in cases where no referral to the State Medicaid fraud control unit is required under paragraph (a)(1) of this section, conduct a full investigation or refer the case to the appropriate law enforcement agency.

(b) If there is reason to believe that a beneficiary has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.

(c) If there is reason to believe that a beneficiary has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

[48 FR 3756, Jan. 27, 1983, as amended at 51 FR 34788, Sept. 30, 1986]

§ 455.16 Resolution of full investigation.

A full investigation must continue until—

(a) Appropriate legal action is initiated;

(b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or

(c) The matter is resolved between the agency and the provider or bene-

ficiary. This resolution may include but is not limited to—

(1) Sending a warning letter to the provider or beneficiary, giving notice that continuation of the activity in question will result in further action;

(2) Suspending or terminating the provider from participation in the Medicaid program;

(3) Seeking recovery of payments made to the provider; or

(4) Imposing other sanctions provided under the State plan.

[43 FR 45262, Sept. 29, 1978, as amended at 48 FR 3756, Jan. 27, 1983]

§ 455.17 Reporting requirements.

The agency must report the following fraud or abuse information to the appropriate Department officials at intervals prescribed in instructions.

(a) The number of complaints of fraud and abuse made to the agency that warrant preliminary investigation.

(b) For each case of suspected provider fraud and abuse that warrants a full investigation—

(1) The provider's name and number;

(2) The source of the complaint;

(3) The type of provider;

(4) The nature of the complaint;

(5) The approximate range of dollars involved; and

(6) The legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred.

(Approved by the Office of Management and Budget under control number 0938-0076)

[43 FR 45262, Sept. 29, 1978, as amended at 48 FR 3756, Jan. 27, 1983]

§ 455.18 Provider's statements on claims forms.

(a) Except as provided in § 455.19, the agency must provide that all provider claims forms be imprinted in boldface type with the following statements, or with alternate wording that is approved by the Regional CMS Administrator:

(1) "This is to certify that the foregoing information is true, accurate, and complete."

(2) "I understand that payment of this claim will be from Federal and State funds, and that any falsification,